Department of Veterans Affairs

Prevention Notes

From the Director's Desk

As we enter the fall season, plans for influenza vaccination should be in place at VHA facilities nationwide. Those plans should incorporate four important steps to assure veterans receive optimal immunization services: *contact, consolidate, convey and communicate.*

Influenza and pneumonia are the fifth leading cause of death among the elderly. Over 60,000 adults in the United States die each year of complications of these diseases. Research studies show that morbidity and mortality are reduced and often prevented by immunization. Everyone over age 65 and those suffering from chronic disease or a weakened immune system needs protection. To be sure they get it, we must contact all who are eligible and track those responding to be sure they avail themselves of the service. Our new veteran enrollment system beginning this fall will enhance our ability to accomplish this task.

Having notified the veteran to come for a shot, clinic staff should seize the opportunity to offer not only influenza vaccine, but also pneumococcal immunization and Tetanus and Diphtheria (Td) toxoid. This requires some sophistication since strategies differ for each shot. Flu shots are needed annually. Td shots are needed each decade. Pneumococcal shots are needed only once. The clinic staff should query veterans and offer one, two or three immunizations depending on each veteran's past experience. Research has shown that you can consolidate all three shots into one visit with no ill effect for the patient and no loss of effectiveness. Getting three shots at once might even bring back fond memories of military induction processing from long ago.

Giving shots is great for preventing physical illness, but good health involves more than that. Veterans who become involved in managing their care program achieve the best results. A new term for this old concept is "patient-provider partnership." One way to encourage this relationship when giving shots is to offer the veteran a card to convey information about vaccine status and when their next shot is due. The card can be stored in a wallet and offers a means to involve the veteran in managing their own health in collaboration with their primary care clinician.

The final step is to be sure that we communicate information to both the medical record and the computerized patient care encounter system. The medical record provides an important avenue of communication among all medical providers addressing the needs of the veteran while the computer offers a means for producing reminders for future services.

The spectrum of activities involved in a simple immunization visit call for practice organization and teamwork. The VA is doing well in this regard as judged by national immunization standards. The goals in *VHA Handbook* 1101.8, which are modeled after the *US Department of Health and Human*

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National Center For NCHPP HEALTH PROMOTION

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Services Healthy People 2000 objectives, call for vaccination rates exceeding 60% for influenza and pneumococcus with 62% for Td. Data obtained from the 1997 *NCHP Veterans Health Survey* show over 70% received their influenza shot. Pneumococcus rates were 59% for male veterans and 65% for females. Td rates were 53% for male veterans and 59% for females. Since pneumococcus immunization is a once-in-a-lifetime proposition (current recommendations) and Td vaccination lasts a decade it should be possible to approach 100% success with these preventive measures if we add them to shots given each year for flu. By *contacting, consolidating, conveying and communicating* we can achieve this goal.

Robert J. Sullivan Jr., MD, MPH
Director
National Center for Health Promotion and Disease Prevention

As this newsletter goes to press, plans are being made for the second annual prevention conference "Integrating Preventive Medicine and Health Education in Primary Care" taking place in New Orleans on September 9 - 11. By the time the newsletter reaches your respective medical center, we will have already met and discussed with many of you, knowledge and experiences related to the implementation of preventive medicine guidelines for the coming year in VHA facilities.

Although the next issue of the newsletter will feature conference highlights, for those of you unable to attend, some thoughts seem appropriate. The overall goal of the meeting is to continue the successful liaison between preventive medicine and patient education launched at the Las Vegas conference last year. Testimony to this partnership are the numerous outstanding action plans that were developed and implemented at individual sites during the past year. This strategy will continue at this year's meeting culminating hopefully in the inauguration of similar plans to serve the health promotion needs of our veterans. A special feature of this year's program will be the participation of VISN representatives from the 22 geographic areas. Their input will be an essential ingredient in the development and implementation of the action plans at the local level.

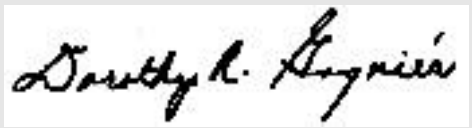
Specific objectives for the training session included: (1) the utilization of evidence-based guidelines in providing preventive medicine services in primary care; (2) the description of new evidence-based recommendations for preventive medicine; (3) details regarding recent controversies in prevention; (4) demonstrations of early identification and intervention, including counseling; (5) network expansion among facility staff and between facilities; (6) utilizing survey results and data resources to expand research opportunities in prevention; and (7) incorporating national standards into preventive medicine program planning at the local level. As they did last year, conference participants will develop facility action plans to enhance prevention activities within their VISNs. A follow-up conference call will be scheduled three months following the conclusion of the program to ascertain progress made in that effort.

PMPC Conference Calls 1997-98

Calls have been scheduled for **October 7, 1997 from 1:00 - 1:50 PM EDT; March 3, 1998, 1:00 - 1:50 PM, EST; and October 6, 1998, 1:00 - 1:50 PM, EDT**. Phone in number for all three calls is through the VANTS system at **1-800-767-1750**. As always, we welcome any other members of your health care team to join us. An agenda will precede the call and be mailed to the preventive medicine program coordinator at your medical center.

We are pleased to feature several articles in this edition authored by professionals in the field. Also included is a questionaire about problem drinking intended for use with patients. If you have a program in preventive medicine or any other type of relevant information you would like to share, call or e-mail me at **FTS 671-5880 Ext. 226 or COM (919) 416-5880 Ext. 226**. My e-mail address is **"dorothy@acpub.duke.edu"**.

Have a great Fall and look for timely information about the happenings in New Orleans in the Winter issue of *Prevention Notes*.



Newsletter Editor
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Reference Manual and Modifiers For Prevention Program Activities

This is a heads up message for primary care clinicians about progress in the areas of coding and use of the new ambulatory care data capture systems in the clinical setting. Insufficient guidance on how to use encounter forms to enhance the clinical and reporting activities of the VA's Preventive Medicine Program is one problem area that has been reported by VHA staff, particularly clinicians. Another is the need for additional definitive ICD and/or CPT codes to accurately describe and distinguish among some of the health promotion services, i.e. counseling for alcohol or tobacco use.

Do not despair, help is on the way. In approximately November, 1997 a workbook and a powerpoint presentation describing the use and clinical benefits of encounter forms and ambulatory care data capture will be distributed from the Employee Education System to the ambulatory care data capture team leaders at each VAMC. In addition, to help with the coding problem, modifiers for existing codes are under development in the Central Information Office. The current plan is for the information systems to be ready to receive transmissions in Austin of the initial set of modifiers in approximately April, 1998.

The workbook is designed as a reference for clinicians, clinical application coordinators, encounter form designers, Automated Data Processing Application Coordinators and others. The workbook will contain modules on 1) encounter forms, 2) health summaries, 3) clinical reminders, 4) problem lists, and 5) PCE reports. The encounter form module will provide guidance for creating and completing encounter forms including how to capture the data for reporting preventive medicine activities. The health summary module shows how to easily retrieve desired information about your patient. The clinical reminders section provides assistance in implementing clinical reminders including notices of when preventive medicine activities were last performed and when they are due. The problem list module gives tips for coordinating the problem list with the encounter form, health summary, and Patient Care Encounter. The PCE report module explains how PCE clinical reports may be used for measuring preventive health and other clinical activities. Contact the ambulatory care data capture team leader at your facility for a copy after November.

Mary Burdick

Mary B. Burdick, Ph.D., R.N.
Assistant Director for Field Liaison
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Translating Evidence Into Practice

The Agency for Health Care Policy and Research (AHCPR) sponsored a meeting in Washington DC in July 1997 focusing on "Translating Evidence Into Practice." Over 300 attendees heard from distinguished clinicians about the need for national coordination and leadership in order to implement effective Evidence Based Medicine.

HHS has announced plans to develop a comprehensive Internet-based source for clinical practice guidelines. The new National Guideline Clearinghouse (NGC) will make available a full range of current guidance on treatments for specific medical conditions. Under the plan, HHS'Agency for Health Care Policy and Research, the American Association of Health Plans and the American Medical Association will work jointly to develop the new guideline clearinghouse. It is anticipated that AHCPR will award a contract later this year for the technical work to establish the NGC.

The development and use of clinical practice guidelines has grown markedly in the past five years. However, many existing and potential guideline users have difficulty gaining access to and keeping abreast of the many clinical practice guidelines currently in use. In addition, existing guidelines often differ in their development and content, further complicating their use. The target date for the new Internet clearinghouse site is Fall 1998.

The Director, Department of Quality and Utilization, the Permanente Medical Group, Inc., Richard B. Rabens, MD, MPH addressed "Strategies for Guideline Implementation: Some Ways To Approach the Issue of 'Usability'." Attention to the issue of provider acceptance and utility needs to be addressed in the process of clinical practice guidelines development and implementation. Guidelines can only be judged as successful if they are used by the groups for which they are intended-providers, other health care personnel, and patients. The program for clinical practice guidelines developed by The Permanente Medical Group, Inc., the medical provider group affiliated with the Kaiser Permanente Medical Care Program in Northern California, has held to five basic principles: (1) the guideline process is sponsored by the Medical Group itself, (2) a wide but manageable team of stakeholders is included in the development and implementation process; (3) evidence-based principles are adhered to whenever possible; (4) academic "detailing" by clinical "champions" is used; and (5) the entire process is rooted in the area of quality, as opposed to cost. Acceptance of the Clinical Practice Guidelines program has grown strongly as the guidelines have been rolled out over 2.5 years.

Two principles were discussed that were relevant for any health care provider and in particular in a nation-wide system: (1) central leadership; (2) local autonomy. Dr. Rabens also stated that cost is no longer the major issue but rather a

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CIGARETTE SMOKING IN WOMEN

The mortality risks associated with cigarette smoking for women are significantly greater today than they were when these risks were presented in the first Surgeon General's Report in 1964, according to a new report released by the National Cancer Institute (NCI). The report entitled *Changes in Cigarette-Related Disease Risks and Their Implication for Prevention and Control* contains newly analyzed data from five of the world's largest epidemiologic studies on smoking and health.

Two of the studies, including one involving veterans began in the 1950s, while the other three studies started more recently (see table 1). Study populations ranged from 60,000 to 1.2 million and the length of follow-up varied from 6 to 26 years. A total of nearly 490,000 deaths were available for analysis across all studies. Taken as a group, these five studies represent over 20 million person-years of observation. According to this report, the risks for all smoking-related causes of death, including lung cancer, other cancers, heart disease, stroke, and chronic obstructive lung diseases have increased among both men and women. And while men who smoke still experience higher risks for these diseases than women, the greatest increase in risks was found in female smokers.

In the new analysis, American Cancer Society (ACS) investigators compared six-year follow-up data from two ACS studies known as *Cancer Prevention Studie*s (CPS) I and II (see table 1). CPS I was initiated in 1959 while CPS II began in 1982. The two studies used nearly identical study designs and methodologies, and each included more than 1 million persons. These studies essentially represent two groups of smokers born approximately a generation apart.

The difference in lung cancer risk between men who smoked and those who did not smoke doubled between studies. In statistical terms, the relative risk increased from 11.9 to 23.2. Smokers studied in CPS I were about 12 times more likely than nonsmokers to die of lung cancer, while smokers studied in CPS II were about 23 times more likely than nonsmokers. Among women, the relative risk increased more than fourfold, from 2.7 in CPS I women to 12.8 in CPS II.

The mortality risks for all other smoking-related cancers combined, which included cancers of the larynx, oral cavity, esophagus, bladder, kidney, and pancreas, increased from 2.7 to 3.5 in male smokers and from 1.8 to 2.6 among female smokers. Relative risk for coronary heart disease (CHD) for men rose from 1.7 in CPS I to 2.3 in CPS II, while the CHD risks in female smokers rose from 1.4 to 1.8. Similar increases were noted for other causes of death.

Results from two other studies that began in the 1970s confirm the results observed among female smokers in CPS II. Data based on 36,035 women in the *Kaiser Permanente Study* and 121,700 women in the *Nurses' Health Study* show that women smokers had nearly twice the risk of death from all causes compared with women who did not smoke. This relative risk of 1.9 was identical to the relative risk found for women in CPS II. Among women in the *Kaiser Permanente Study*, relative risks for all the major smoking-related diseases were similar to those found among women in CPS II. For example, the mortality risk for lung cancer among women smokers in the *Kaiser Permanente Study* was 15.1, compared with 12.8 among CPS II women. For CHD, the relative risks were 1.7 and 1.8 in Kaiser and CPS II, respectively; and for chronic obstructive lung disease the relative risks were 9.0 in Kaiser and 12.8 in CPS II.

The increase in mortality risk from cigarette smoking related diseases occurred during a time when significant declines in machine-measured tar and nicotine yields of cigarettes were being reported. The average tar level per cigarette has declined nearly 70 percent since 1955, from approximately 38 mg to 12.5 mg today. Similarly, nicotine levels fell from an average of 2.6 mg per cigarette to under 0.9 mg over the same time period. Yet the relative risks for all major smoking-related causes of deaths increased. The increase in relative risk is considered to be due to a greater lifetime dose of cigarette smoke received by smokers in the more recent studies compared with smokers included in the studies from the 1950s and early 1960s. For example, women in the contemporary studies started smoking in their teens, while many of those in the older studies began smoking later in life. The decline in nicotine content and the concomitant increase in numbers of cigarettes smoked are linked and those with a nicotine addiction who receive less nicotine per cigarette require to smoke more cigarettes in order to maintain their nicotine intake.

Smokers in the newer studies consumed more cigarettes per day than smokers followed in earlier studies, and much of the difference in risk disappears when duration of smoking history and number of cigarettes smoked per day are held constant. A substantial literature base also exists which shows that smokers today are smoking each cigarette more intensively than smokers did 40 years ago, with larger puffs and deeper patterns of inhalation.

The major prospective studies summarized in this report are important cornerstones for documenting smoking-induced diseases not only because of the size of the popu-

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lations involved but because the participants were essentially healthy at the start of the studies. The findings emphasize the enormous risks posed by cigarette smoking. Although preventing adolescent smoking will have the greatest benefit for society in the long run, the benefits of cessation to adults who currently smoke are substantial, and declines in smoking among this group could reduce death rates in as little as five years.

Copies of the report entitled Changes in Cigarette-Related Disease Risks and Their Implication for Prevention and Control are available from the National Cancer Institute's Cancer Information Service at ***1-800-4-CANCER.***

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Table 1

Characteristics of Study Populations for the Five Major Prospective Studies

Study Title (Year)	Total size of cohort	Females in cohort (%)	Years of follow-up	Approx. no. of deaths
U.S. Veterans (1954)	300,000	< 1%	2-6 years	198,000
CPS I* (1959)	1,078,894	52%	12 years	205,000
Kaiser Permanente (1979)	60,838	59%	6.1 years**	3,000
Nurses' Health Study (1976)	121,700	100%	12 years	2,800
CPS II* (1982)	1,185,106	57%	6 years	79,800

* CPS = Cancer Prevention Study ** Mean number of years follow up

PHYSICIAN ASSISTANT HANDBOOK AVAILABLE

The Veterans Administration is undergoing a major restructuring process with a greater emphasis on primary care and preventive services. The VA document *Vision for Change* states that utilization of non-physician primary care providers will serve as a method to expand patient access and decrease waiting times while also reducing cost. *Prescription for Change* develops this notion a bit further when it declares a budget-neutral action plan will increase the number of VA non-physician primary care providers by 200 percent over the next several years.

Although utilized in a wide variety of settings, physician assistants (PA) are ideally suited to providing primary care. PA education is almost universally primary care oriented. Physician assistants have established a reputation as providers of high quality, cost-effective, accessible health care. Barriers to effective PA use within the VHA include low starting salaries, difficulty in recruitment and retention, and variations in local supervision and prescribing policies.

The VA Headquarters Physician Assistant Field Advisory Group under the direction of Dr. Ronald Gebhart, Chief Consultant, Primary/Ambulatory Care, has developed a *Physician Assistant Employment Handbook* that addresses some of these issues. It includes sections on advertising, salary and benefits issues, special salary rates and policies pertaining to recruitment, relocation and retention. The Office of Health Care Staff Development and Retention assisted in the production of the manual. Two copies have been mailed to each facility.

For more information about the manual, contact Rebecca A. Goldsmith, PA-C, Member, VA Physician Assistant Field Advisory Group.

FY 1997 Veterans Health Survey

One of the responsibilities of the NCHP is to report to Congress annually on the rates that veterans who receive care at our VHA facilities receive health promotion and disease prevention services defined in *VHA Handbook* 1101.8. The current list includes 13 evidence-based services that are recommended as a minimum for all average risk veterans receiving primary care at VA facilities.

The recommended intervals are for normal or average risk individuals. Any veteran with an elevated risk due to family history, concurrent diseases, lifestyle, or other reason may require more frequent screening. The primary care provider can arrange the optimal schedule in these cases.

Results of the FY 1997 Veterans Health Survey

Random samples of 300 men and 150 women from each of 153 VA facilities were selected (eleven sites did not have 150 women eligible; we selected all who were eligible in those instances). Eligibility was defined as living in the community with a post office address and having received primary care at least once during calendar year 1996 from any of these clinics: General Internal Medicine (301), Geriatric Clinic (318), Geriatric Evaluation and Management Clinic (319), Women's Clinic (322), and the Primary Care/Medicine Clinic (323). We achieved a 68% adjusted response rate after two mailings (44,304 respondents in total ÷ 68,422 – 2,984 ineligibles). The data were optically scanned into a computer and 100% verified on screen.

Based on these responses, we calculated rates for each of the 13 prevention services for each VAMC, and the weighted averages for VISNs and the VHA as a whole. The VHA data are presented in the following table.

Both male and female veterans currently exceed the U. S. Year 2000 Goals in two areas (hyperlipidemia screening and influenza immunization) and the female veterans exceeded the US Year 2000 goals in four additional areas (pneumococcal vaccine, cervical cancer screening, breast cancer screening, and seatbelt use). The preventive practice most in need of attention is counseling for problem drinking and alcohol moderation. Accordingly, the PMFAG has adopted this area for the special initiative in FY 1998.

(Survey results on opposite page)

Larry Branch

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National Center for Health Promotion and Disease Prevention

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question of value: "Do we take better care of our patients than our competitors do?"

Ronald Gebhart, MD, Chief Consultant, Primary/ Ambulatory Care, Veterans Health Administration presented: "Implementation in Managed Care-Lessons Learned." The presentation included a discussion on the process and implementation of the Clinical Practice Guidelines that have been promulgated in the VHA. It was reported that: "local champions of guideline development and implementation have proven essential to successful implementation."

The Executive Director at Brigham and Women's Physician Hospital Organization, Boston, Troyen Brennen, M.D., J.D, M.P.H. addressed: "Practice Guidelines and Malpractice Litigation: Collision or Cohesion?" Dr. Brennen defined practice guidelines as standardized specifications for managing particular clinical problems and indicated that they are intended to improve the outcomes of medical care by increasing adherence to standards of care. They are also meant to make medicine more cost-effective by eliminating unnecessary procedures. The practice guidelines now emerging will have implications for malpratice.

Dr. Lawrence G. Smith, M.D. spoke on: "Evidence-Based Medicine: A Cultural Shift in Residency Training." The strong emphasis on evidence-based medical practice throughout the United States and Canada has fallen on many receptive ears throughout the medical education arena. However, there has been a distinct problem converting evidence-based philosophy to actual clinical practice. The problem stems from various factors, including inefficient procedures for finding evidence, time delays, lack of role models, lack of adequate evidence to answer many clinical questions, and complex patients with multiple disease processes that do not fit into a single, neat diagnostic category.

One obvious barrier to implementation of evidence-based practice has been the lack of cultural acceptance of this paradigm at the senior physician level. Older physicians frequently see evidence-based medicine as "cookbook medicine," that may devalue personal clinical experience and expertise.

Dr. Smith spoke about the impact of evidence-based medicine in a hospital setting. "We have undertaken a project to bring about a cultural shift at Mount Sinai Hospital, so that evidence-based medical practice becomes culturally acceptable and ultimately becomes the norm, where adequate evidence exists. The framing of clinical questions from an evidence-based perspective now takes place on a regular basis at all morning report sessions, and at many attending rounds. Residents receive formal instruction in literature-searching techniques, with ready availability of computers and access to databases throughout the pro-

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FY 1997 Veterans Health Survey

	VA Goals for Year 2000[a]	VHA Rate[b] FY1997 (max n = 44,304)
PRIMARY PREVENTION (AVOIDANCE)		
1. HYPERTENSION		
% of males with blood pressure check in the past 2 years	90%	88%
% of females with blood pressure check in the past 2 years	90%	87%
2. HYPERLIPIDEMIA		
% of males age 35 to 65 with cholesterol checked in the past 5 years	75%	**79%**
% of females age 45 to 65 with cholesterol checked in the past 5 years	75%	**82%**
3. INFLUENZAIMMUNIZATION		
% of males age 65 and older who received an influenza vaccine this year	60%	**75%**
% of females age 65 and older who received an influenza vaccine this year	60%	**73%**
4. PNEUMOCOCCAL VACCINE		
% of males age 65 and older who received pneumococcal vaccine at least once	60%	59%
% of females age 65 and older who received pneumococcal vaccine at least once	60%	**65%**
5. TETANUS		
% of males receiving Td booster at least once in the past decade	62%	53%
% of females receiving Td booster at least once in the past decade	62%	59%
SECONDARY PREVENTION (EARLY DETECTION AND TREATMENT)		
6. CERVICALCANCER DETECTION		
% of females under age 65 with Pap test in the past 3 years	85%	**89%**
7. BREASTCANCER DETECTION		
% of women age 50 to 69 who received a mammogram in the past 2 years	60%	**85%**
8. COLORECTALCANCER DETECTION		
% of males over age 50 receiving a fecal occult blood test this year	50%	33%
% of females over age 50 receiving a fecal occult blood test this year	50%	29%
ASSESSMENTAND COUNSELING, if appropriate, for:		
9. TOBACCO USE COUNSELING		
% of males who are current tobacco users	15%	30%
% of females who are current tobacco users	15%	27%
% of male tobacco users offered counseling	100%	73%
% of female tobacco users offered counseling	100%	78%
10. PROBLEM DRINKING AND ALCOHOLMODERATION COUNSELING		
% of males asked/screened for problem drinking and alcohol use this year	100%	29%
% of females asked/screened for problem drinking and alcohol use this year	100%	21%
11. WEIGHT CONTROLAND NUTRITION COUNSELING		
% of males receiving nutrition counseling this year.	100%	49%
% of females receiving nutrition counseling this year.	100%	45%
12. PHYSICALACTIVITYCOUNSELING		
% of males receiving activity counseling this year	100%	57%
% of females receiving activity counseling this year	100%	55%
13. SEATBELT AND ACCIDENT AVOIDANCE COUNSELING		
% of males receiving seatbelt use/accident avoidance counseling this year	100%	11%
% of females receiving seatbelt use/accident avoidance counseling this year	100%	10%
% of males reporting "almost always" using seatbelts	85%	70%
% of females reporting "almost always" using seatbelts	85%	**85%**

a. *VA Handbook* 1101.8.
b. Weighted as appropriate; 95% confidence interval for the VHAis less than ± 1%.

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gram. In addition, there has been significant faculty development, and a core faculty knowledgeable about evidence-based medicine now has a strong presence throughout medical service.

The department has also placed academic generalists in high-profile roles throughout teaching programs, enhancing the role model effect of the actual practice of evidence-based medicine. This multipronged approach has been extraordinarily successful. Not only has there been a dramatic cultural shift in the way residents approach cases, discuss them, and think about clinical decisions, but there also has been gradual acceptance by the attending staff of many of these new paradigms of thinking. Through a process of careful nonconfrontational education in evidence-based approaches, we have found that residents can learn from all attending staff and incorporate what they learn from many practice styles into an organized, evidence-based approach to patient care. The ultimate personal clinical style of each resident seems to incorporate the 'best of both worlds.'

The results of this gradual process have been positively received by house staff. This has translated into a new format of teaching for medical students rotating on the internal medicine service. It is gradually being incorporated into such areas as care paths, practice guidelines, and order sets. All of this has occurred with emphasis on the best available data, and with heavy participation of the residency in the design, implementation, and ongoing surveillance of these projects."

The **Agency for Health Care Policy and Research Web site is: http://www.ahacpr.gov/**

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Clinical Program Manager
Primary/Ambulatory Care Office (112)

CheckUp

Self-Test for Signs of Alcoholism

The first and often the toughest step in beating a problem is recognizing it exists. To test whether you or someone you know needs to find out more about alcoholism, answer yes or no to this series of questions.

1. Do you ever drink heavily when you're disappointed, under pressure or have had a quarrel with someone? ☐ Yes ☐ No
2. Can you handle more alcohol now than when you first started to drink? ☐ Yes ☐ No
3. Have you ever been unable to remember part of the previous evening, even though your friends say you didn't pass out? ☐ Yes ☐ No
4. When drinking with other people, do you try to have a few extra drinks when others won't know about it? ☐ Yes ☐ No
5. Do you sometimes feel uncomfortable if alcohol is not available? ☐ Yes ☐ No
6. Are you in more of a hurry to get your first drink of the day than you used to be? ☐ Yes ☐ No
7. Do you sometimes feel a little guilty about your drinking? ☐ Yes ☐ No
8. Has a family member or close friend ever expressed concern or complained about your drinking? ☐ Yes ☐ No
9. Have you been having more memory "black-outs" recently? ☐ Yes ☐ No
10. Do you often want to continue drinking after your friends say they've had enough? ☐ Yes ☐ No

If you answered "yes" to any of these questions, you have symptoms that may indicate alcoholism.

For a more in-depth quiz, and/or more information about alcoholism, please contact the National Council on Alcoholism and Drug Dependence at (800) NCA-CALL.

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